KENNEWICK SCHOOL DISTRICT 17
Physical Evaluation (valid for 2 years)

Section A: To be completed by Parent ☐ Male ☐ Female

Student Name _____Birth Date_____ Exam Date_____

Address_____City_____Phone _____

Grade in the Fall _____ School in the Fall _____

Activity: Fall _____ Winter _____ Spring _____

Explain all "Yes" answers with dates and details.

Yes	No	
		Have you had any illness/ injury recently, or do you have an illness/injury now? Explain:
		Have you had a medical problem, illness or injury since your last exam? List:
		Do you have any chronic or recurrent illness? List:
		Have you ever had any illness lasting more than a week? List:
		Have you ever been hospitalized overnight? Explain:
		Have you had any surgery other than tonsillectomy? List:
		Have you had any injuries requiring treatment by a physician? List
		Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? List:
		Are you presently taking ANY medications (including birth control pill, vitamin, aspirin etc) List
		Do you have ANY allergies (medicine, bees, foods etc.) List:
		Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
		Do you tire more easily or quickly than your friends during exercise?
		Have you ever had any problem with your blood pressure or your heart?
		Have any of your close relatives had heart problems, heart attack or sudden death before they were age 50?
		Do you have any skin problems (acne, itching, rashes, etc.)? list:
		Have you ever had fainting, convulsions, seizures, or severe dizziness?
		Do you have frequent severe headaches?
		Have you ever had a "stinger" or "burner" or pinched nerve?
		Have you ever been "knocked out" or "passed out"? Date and details:
		Have you ever had a neck or head injury? Date and severity:
		Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
		Have you had asthma, or trouble breathing, or cough during or after exercise?
		Do you wear glasses or contacts or protective eye wear?
		Have you had any problem with your eyes or vision
		Do you wear any dental appliance such as braces, bridge, plate, retainer?
		Have you ever had a knee injury?
		Have you ever had an ankle injury?
		Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
		Have you ever had a broken bone (fracture)?
		Have you ever had a cast, splint, or had to use crutches?

Expiration Date:

Yes	No	
		Must you use special equipment for competition (pads, braces, neck roll, etc.)?
		Has it been more than 5 years since your last Tetanus booster shot?
		Are you worried about your weight?
		Females: Have you any menstrual problems?
		Have you any medical concerns about participating in your sport?

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Student Signature _____ **Date** _____

Parent/Guardian Signature_____ **Date** _____

Section B – PHYSICAL EXAMINATION - To be completed by Physician

Age _____ Height _____ Weight _____ BP _____ Pulse _____ Visual Acuity L 20/ R 20/			
	Normal	Abnormal Findings	Initials
Head			
Eyes, ENT			
Teeth			
Chest			
Lungs			
Heart			
Abdomen			
Genitalia			
Neurologic			
Skin			
Physical Maturity			
Spine, Back			
Shoulders, Upper extremities			
Lower extermities			

Assessment: ☐ Full Participation

☐ Limited Participation (describe limitations, restrictions in box below)

☐ Participation contraindicated (list reasons in box below)

Recommendation (equipment, taping, rehab etc.):

Date:_____Examiner's signature_____Print Examiner's name_____